When Hospital Boards Merge: 5 Lessons Learned

By Barry S. Bader

The flurry of hospital mergers that marked the 1990s has subsided, but health systems have continued to redesign their governance structures, sometimes on multiple occasions, in search of the synergies that drove those initial consolidations. Frequently, the governance structure that a newly merged healthcare system adopts is a transitional vehicle, although it's seldom called temporary at the outset. Seats on the parent board initially are divvied up proportionally among the affiliates, while the boards of subsidiary facilities may remain in place with reduced powers.

After a few years, if all goes well, the merged system yields demonstrable benefits, trust builds and board members from one-time competitors think about what's good for the system as a whole rather than what benefits their individual entities. At the same time, some shortcomings of the initial board structure, such as overly large boards and trustees of subsidiaries who feel they lack important responsibilities, become evident. That's when many systems form a governance task force to reassess and redesign the structure of the board.

In interviews with health system leaders about what they have learned as governance evolves, five key themes emerge.

1. The importance of a shared and compelling system vision. The governance structure should facilitate the adoption of a shared vision in which the merged organization outperforms what its constituent entities could have done individually.

"We started with a vision and tested everything against the vision," explains Brian Lockwood, CEO of Community Health Partners, the result of a 1994 merger of two hospitals four miles apart in Lorain, Ohio. "The vision was one hospital on two campuses, with one board, one medical staff and one management team."

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The shared vision paved the way for reallocating clinical services more rationally to meet the whole community's needs, with one campus now housing all inpatient care.

Getting all board members focused on what's best for the merged system as a whole and for the entire community it serves can be a tall order when many trustees have dedicated years to separate facility agendas. It takes effort.

At Crozer Keystone Health System, a five-hospital system in the Philadelphia/Delaware Valley market, systems thinking has become part of the culture and means a "recognition that being a system really matters, as opposed to only my institution matters," CEO Gerald Miller explains.

Management promotes systems thinking though such deliberate practices as presenting budgets in rolled-up formats and discussing individual facility tactics as part of the larger, system-wide strategy. Rather than developing strategic plans first at a facility level, strategic plans are developed through a "matrix or mosaic process" that has wide inclusion from subsidiaries, with the parent board ultimately approving overall plans and debt authorizations.

2. The structure of the board should be streamlined and structurally aligned to add value.

As they mature, multi-hospital systems typically engage in redesign efforts that reduce duplicative, confusing governance layers that don't add value. They often downsize large boards chosen on a representational basis and end up with a parent board of about 15 members. Some are moving away from institutional boards and toward boards that govern multiple facilities in a "natural market."

Medical staff mergers may follow if the facilities are geographically close, enabling physicians to promote a single

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quality standard and conduct medical staff activities more efficiently.

Community Health Partners went through two governance redesign processes, first forming separate boards with overlapping members and later merging into a single "mirror board" with the same 16 members serving as the board of the holding company, hospital, medical office building and for-profit subsidiary company.

Bronson Healthcare Group in Kalamazoo, Mich., initially downsized from 20 boards with 130 members to a single, 22-member system board. Subsequently, it streamlined further to a 15- to 20-member board, with heavy reliance on working committees and increased board education. The system board is now the mirror board for its subsidiaries.

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From the outset of its formation, Crozer Keystone Health System replaced its facility boards with a two-tiered structure: A parent board governs the whole system while a Health Services Board oversees five hospitals and other delivery enterprises.

Working committees are often a powerful integrating mechanism. Texas Health Resources, a 13-hospital system in the Dallas-Ft. Worth area, has maintained its facility boards but it promotes synergies through six system-level board committees. The committees are responsible for:

- Finance, with subcommittees for facilities development/real estate development and investments.
- Audit and compliance.
- People and culture.
- Quality and performance improvement.
- Strategic planning.
- Governance (includes executive compensation).

With one exception, each THR board committee is chaired by a parent board member and includes members from THR's hospital boards. Only the governance committee is composed exclusively of parent board members.

In a multi-tiered board structure, every level of governance should add value; that is, it should make a positive, non-duplicative contribution to advance the organization and to help management.

The board of Northeast Health of Troy, N.Y., a system composed of two hospitals on opposite sides of the Hudson River and a nationally known geriatric services organization, first restructured several years ago. It ended up with three boards: a parent board, an acute care board over its two hospitals and a board for The Eddy, its elder services organization.

It became evident last year that although each board was dedicated and hard-working, the structure was still perpetuating "us-and-them" thinking, making it harder to move to the next phase of system-wide synergy. Last fall, the NEH board approved a transition to a single board in 2004. A blue-ribbon committee composed of the chairs of the parent, acute care and Eddy boards and the chairs of the governance and nominating committees will nominate the new board.

"We've tried to promote systems thinking," says CEO Craig Duncan. "This is the next logical step."

Where facility boards remain, it's important that their roles are genuine, meaningful and clear. Texas Health Resources tries to foster that with a written "authority matrix" that clearly describes the authority and responsibilities of the parent board and those of the boards of the individual facilities.

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Lessons from Hospital Board Mergers

√ Get buy-in to a compelling system-wide vision and strategic direction.
√ Streamline the board structure and align it with the strategy.
√ Pay attention to culture.
√ Select board members for their competence and objectivity, not to represent constituencies.
√ Invest in board education.
√ Revisit the structure several years after the merger and assess whether further changes are needed.

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In addition, THR entities have standardized articles and bylaws, as well as a roles and responsibilities document that compares the roles of the parent board, facility boards, committees and management.

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"We have a very organized and integrated way of operating," says Luanne Armstrong, THR's vice president of governance.

Redesign efforts don't always eliminate boards. The trustees at Mountain States Health Alliance in Johnson City, Tenn., performed double duty as a system board and the board of Johnson City Medical Center, a large and complex teaching facility. When Mountain States acquired several area facilities formerly owned by HCA, a governance task force decided that governing a much larger regional system and overseeing the medical center were too much for the parent board.

So a governance task force recommended creation of a new subsidiary board to oversee the medical center and MSHA's other facilities serving Johnson City and Washington County.

CEO Dennis Vonderfecht says the added governance tier has worked well by freeing the system board to focus on system-wide finances and strategy while the Washington County board and another subsidiary board concentrate on local quality, medical staff and operational issues with facility-level executives.

3. Careful attention to the culture.

Governance should build bridges to optimize the strengths of its member organizations, but successful leaders take care not to trample on the strong cultures and sensitivities of local communities, facilities and medical staffs.

That was true at Community Health Partners in Lorain, Ohio, says Lockwood. "Even though both hospitals served the same community and were just four miles apart, the cultures were different. Time was needed to allow gradual development of a new, single culture. That's one reason why the governance structure evolved in two stages: first a representational, tiered governance model that preceded today's more unified, mirror board model.

Medical staffs are a key part of organizational culture. Physicians accustomed to direct access to a hospital board can feel disenfranchised when final authority for finance and strategic planning shifts to a system board.

Besides retaining facility boards, Texas Health Resources strives to give physicians a voice in system-wide clinical planning and operations through a Physicians Leadership Council that THR President and CEO Douglas D. Hawthorne says "provides excellent input. After several years of development, it is starting to come into its own."

In addition, the membership of each of the THR parent and facility boards includes at least three physicians, and the chair of the Physicians Leadership Council serves ex-officio with a vote on the parent board.

Crozer-Keystone uses a different approach, creating what it calls "policy committees" of leaders at its larger, more complex facilities to provide a forum for attention to local facility issues and an avenue to make recommendations to the Health Services Board. Top-level managers and a few trustees serve with physician leaders on the policy committees.

4. Competency-based composition and physician involvement.

A key to health system success is selection of board members who are objective, system oriented and bring the particular knowledge and skills needed to govern a larger organization serving a wider community than a single facility would.

In a sense, post-merger governance is like a good wine that gets better with age.

Fairview Health System, based in the Twin Cities but serving communities with facilities throughout Minnesota, revamped its governance in 1998, after adding the University of Minnesota Hospital and several other healthcare

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organizations during the 1990s. At that time, Fairview left in place a board of more than 35 members, many chosen by constituent boards, but it empowered a 13-member executive committee to function as an operating board to optimize system strengths.

In a second redesign process in 2002, Fairview downsized from 38 to 21 members. Most critically, subsidiary boards will not elect members to the parent board, but rather, they will make nominations, says legal counsel George Chresand. Board selection will be guided by objective criteria describing the desired skills and traits of board members, and the system board has the final say.

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Many systems also seek significant physician involvement in governance and leadership. For example, 30 percent of Bronson Healthcare Group's board members are physicians. Crozer Keystone has seven or eight physicians on each of its policy committees.

5. Commitment to board education.

As they downsize and streamline, health systems also are reallocating their time to devote more attention to education and substantive discussion of critical issues at meetings and retreats. Consent agendas are increasingly used to handle routine business efficiently.

The Bronson board meets monthly for about two hours, with half the time devoted to education on a national issue or a local initiative.

Texas Health Resources also devotes a portion of each board meeting to discussion of a national issue or challenge, as well as having two system-wide governance retreats of three days and one and one-half days, respectively.

One retreat is for all board members as well as physician leaders and senior executives. A second is for the parent board, chairs of the facility boards, medical staff presidents and senior management.

Reassess Every Few Years

Some health systems, like Crozer Keystone, have pretty much the same governance structure they created at the time of their initial mergers, and they fine-tune it from time to time. Others—like Community Health Partners, Bronson Healthcare Group, Fairview Health System and Northeast Health—have gone through several structural iterations.

In a sense, post-merger governance is like a good wine that gets better with age. Health system trustees and healthcare executives are learning from experience about the best ways to structure their boards of trustees and engage in board work.

"We couldn't have done initially what we did now" is a common refrain from governance task forces that engage in one or more redesigns of their start-up structures. Some downsize while others redefine the roles of facility boards, reduce unnecessary layers and committees, and abandon proportional representation.

By periodically taking a candid look at their roles, organization, composition and the way they conduct business, boards can be certain they have right structure for the foreseeable future.

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